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Published in:
Scandinavian Journal of Public Administration

Publication date:
2017

Document version
Publisher's PDF, also known as Version of record

Citation for published version (APA):
Vrangbæk, K., Arrevaara, T., Hansen, H. F., & Keskimaki, I. (2017). Health care and higher education governance: The role of the economic crisis. *Scandinavian Journal of Public Administration*, *21*(1), 9-31.

Download date: 05. maj. 2023

SJPA
21(1)

Health Care and Higher Education Governance: The Role of the Economic Crisis

Karsten Vrangbæk, Timo Aarrevaara, Hanne Foss Hansen and Ilmo Keskimäki*

Karsten Vrangbæk
Department of Political Science, University of Copenhagen
kv@ifs.ku.dk

Timo Aarrevaara
Faculty of Social Sciences, University of Lapland
timo.aarrevaara@ulapland.fi

Hanne Foss Hansen
Department of Political Science, University of Copenhagen
hfh@ifs.ku.dk

Ilmo Keskimäki
National Institute for Health and Welfare, Department of Health and Social Welfare
ilmo.keskimaki@thl.fi

Keywords:
Crises reactions
Healthcare
Higher education

Scandinavian Journal of Public Administration
21(1): 9-31
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ISSN: 2001-7405
e-ISSN: 2001-7413

Abstract

The paper contributes to the existing literature on reactions to economic shocks by adding a specific comparative focus on core welfare sectors within the Nordic region. Comparing crisis reactions across two countries using a framework of "cost saving", "reorganisation" and "programme" logic reveals patterns and constraints in different institutional settings. The paper concludes that Denmark and Norway initially tried to shelter the health care and higher education sectors, but they have moved on to more radical strategic responses as the crisis has persisted. Many similarities in the crisis reactions are apparent across the two countries and sectors, but important differences are also clear that may be ascribed to the specific institutional contexts.

Introduction

Welfare states have generally proven resilient to changes in both substance and institutional structure (Pierson, 2000). This is true for welfare states in general and particularly in sectors with highly skilled professional groups, such as health care workers and academics (Buse et al., 2005; Wilsford, 1994). However, external shocks (such as the economic crisis of 2008) can lead to disruptions in societal and political perceptions of appropriate policies and values (Selznick, 1957; Suchman, 1995; Alink et al., 2001). This may facilitate a range of different policy responses. In this paper, we will employ a framework of different policy responses to identify patterns of adjustments to economic crisis within two core welfare sectors. Based on a brief review of the crisis response literature, we suggest that response patterns may be dominated by "cost saving logic", "reorganisation logic" or "programme logic". All three types of logic

***Karsten Vrangbæk**, is professor at University of Copenhagen, head of Center for Health Economics and Policy and theme leader in Center for Healthy Aging at University of Copenhagen. His research interests include comparative health policy, health economics and public administration. He has published extensively in international journals and books on these topics.

Timo Aarrevaara is a Professor of public management at the University of Lapland, and has professional experience in public administration as well as in research and teaching. Professor Aarrevaara has been the principal investigator in a number of research projects, including "The changing academic profession in Finland" based on the international Changing Academic Profession (CAP) project, "The changing academic profession: the impact of globalization, diversification and institutional reorganization on academic work and employment conditions in Finland" (EUROAC-FIN) and a work package leader in the Public Engagement Innovations for Horizon 2020 (PE2020). He is a co-editor of Springer's The Changing Academy Series.

Hanne Foss Hansen, Ph.D, is professor at the Department of Political Science, University of Copenhagen. Her research interests include public sector organization, reforms and change as well as evaluation and evidence-based policy and practice. She has worked both with overall public sector analyses and studies of higher education and research.

Ilmo Keskimäki, graduated in medicine and has training for public health and health services research. At present, he is research professor at the Finnish National Institute for Health and Welfare (THL) and professor of health services research at the University of Tampere. His research has addressed several pertinent topics in health services including socioeconomic equity, practice variations, care of chronic conditions, and impacts of health system reforms. Currently, he is leading research on changing competence requirements among health and social care workforce and approaches to monitor quality and outcomes in health services.

may be applied with different degrees of severity, ranging from limited and incremental changes to broader strategic changes. Furthermore, they may be accompanied by different types of managerial approaches, such as business case assessments, performance management, economic incentives and innovation processes. A detailed presentation of the framework is presented in the theory section below.

The paper contributes to the existing literature on reactions to economic shocks by adding a specific comparative focus on core welfare sectors within the Nordic region. Comparing crisis reactions across countries and sectors can help us understand patterns and constraints in different institutional settings. Health care and higher education are particularly interesting, as they represent sectors with a high degree of public involvement and a strong reliance on academic and medical professionals, which are normally associated with resilience to externally imposed reforms. Yet an external shock, such as the economic crisis after 2008, may disrupt this picture. Gaining more knowledge about this issue and the different policy response patterns is highly relevant as the low economic growth rates appear to persist.

Theoretical perspectives for analysing sector responses to a crisis

The concept of crisis

A *crisis* can be defined as "a serious threat to the basic structures or the fundamental values and norms of a system, which under time pressure and highly uncertain circumstances necessitates making vital decisions" (Boin et al., 2005: 2). An economic crisis implies a shift from a period of economic growth to a situation with decreasing or even negative growth rates, and from a situation with abundant resources to a situation with resource scarcity. A crisis creates collective stress and challenges traditional political and administrative reactions (Boin & Hart, 2012: 179).

On one hand, for political and administrative leaders, a crisis can be a time where they risk failure and blame. On the other hand, it also presents opportunities to demonstrate leadership and introduce policies which in normal times would be unthinkable, a situation often described as a window of opportunity (Kingdon, 1995). Similarly, it has been argued that crises are important for the legitimacy of decision makers and provide opportunities for undertaking controversial reforms and system-wide innovation (cf. Mahoney & Thelen, 2010). Each crisis has a material and tangible character, but when the seriousness of a crisis is realised, a political construction of the event evolves (Marcussen & Ronit, 2011: 29−30).

Crisis reactions

Confronted with an economic crisis, policymakers are faced with a number of difficult choices. They must address the immediate reductions in revenue that limit their ability to allocate resources to preferred societal sectors and activities.

The public administration literature on crisis responses and cutback management offers several typologies, summed up in table 1.

Table 1: Crisis responses and cutback management strategies

Author	**Focus**	**Typology**
Jørgensen (2011)	Variations in response types across time:	1) Decremental phase, 2) management phase, 3) strategic phase
Hood (2010)	Different types of reforms:	1) Readjustment of already ongoing reforms to times of scarcity, 2) system redesign, 3) "East of Suez" moments (closing down).
Pollitt (2010)	Different types of cutbacks:	1) Decremental "cheese slicing", 2) productivity and efficiency gains, and 3) strategic cutbacks
Mladovsky et al. (2015)	Different general response types:	1) Get more out of the available resources through efficiency gains, 2) spending cuts and coverage restrictions/reduced service levels, and 3) mobilising additional public (or private) revenue.

The table illustrates many similarities across the different typologies but also depicts elements of diversity. Jørgensen contributes by stressing that the duration of a crisis influences the response types. The immediate response to economic scarcity is normally decremental. Budgets may be reduced by a uniform percentage, and investments may be postponed. If the crisis continues, other strategies are used. Managerial strategies aim to rethink public organisations to increase productivity, while broader strategic responses involve prioritisation between activities and programmes. Hood contributes by pointing out that crisis-related reforms may have different operational focus points. Reforms may readjust recently implemented reforms to the new context of scarcity, they may redesign systems more radically, or they may involve decisions about closing down activities and programmes.

Pollitt clarifies different types of cutbacks by distinguishing between cheese slicing, productivity and efficiency gains, and strategic cutback decisions. In addition, Pollitt stresses that different strategies have different advantages and disadvantages for political and administrative leaders. By using "cheese slicing", politicians avoid prioritising and they may be able to blame administrative leaders for unpopular decisions. Using strategies which aim for productivity and efficiency improvement may be more palatable than outright cutbacks, but their feasibility can be reduced, as they often require initial investments in technology or a redesign of work processes. Using strategic cutbacks keeps politicians in

control but also places them in a situation where they have to take responsibility for difficult and potentially unpopular decisions.

Finally, Mladovsky et al. contribute by stressing that in addition to increasing efficiency and downsizing, decision makers may respond to a crisis by trying to mobilise additional public or private funding by increasing taxes, user payments and so on.

Drawing on inspiration from the literature discussed above, Hansen and Kristiansen (2014) developed a combined typology, which is presented in a simplified version in table 2. The idea is that crisis responses have at least two important dimensions: the *logic* of the strategies and the *level* of the change processes. The logic of changes can be either cost saving, reorganisation or programme change. A cost-saving logic involves decisions on levels of cost savings and their subsequent implementation. Using a reorganisation logic means making decisions on organisational reform based on the assumption that organising differently can create savings. Finally, using a programme logic means responding to cutbacks through changing programmes, services, regulations and inspection procedures. Each of the three logics can be applied with varying degrees of severity. At one end of the scale, we find minor incremental adjustments, such as decremental cost savings and limited adjustments of programs and organisations. At the other end, we find major strategic changes, such as severe cutbacks, elimination of entire programmes and fundamental systems redesign.

Combining the two dimensions creates six different response types for economic crises, as illustrated in the following table.

Table 2: Logics and change processes in crisis response

	Logic of strategies / ***Process of Change***	**Cost-saving logic**	**Reorganisation logic**	**Programme logic**
	**Incremental**	Gradual cost savings	Resetting reform elements from the past to an age of fiscal consolidation	Marginally changing programmes, welfare services and inspection routines
	Strategic	Substantial savings	Systems redesign	Strategic prioritising and cutting away (ineffective) programmes, services and regulation regimes

A previous version of this table was presented in Hansen and Kristiansen (2014).

The six response types may be combined with different types of managerial policy instruments. Business case analysis is commonly used as part of the decision process to undertake new policies. Internal and external policy innovation processes are often employed to determine where cost savings can be applied and how system or programme redesign can best take place. Similarly, most change processes involve a degree of stakeholder management to solicit input and decrease resistance in the implementation phase. Finally, crisis situations are often used as stepping stones to introduce performance management schemes and to strengthen control from central policy actors (Lewis, 2016; Pollitt & Bouckaert, 2011).

Crisis responses may thus include several different patterns and trajectories. Politicians may, for instance, decide to cut back ministries' budgets by 5% using incremental cheese slicing. If politicians do not decide how the cuts have to be implemented, ministries may choose to implement the political decision in different ways. One ministry might simply apply the 5% cut across subordinate organisations, while another might choose to reorganise by merging agencies to profit from benefits of scale (a strategic reorganisation strategy). A third ministry may make the cutback by cutting a programme which has proven to be ineffective or unpopular (a programme strategy).

A type of strategic crisis reaction that usually aims to combine cost saving and reorganisation is to transfer more responsibility to private actors. This can be an (unintended) consequence of reducing the level of public service, but it may also be supported by conscious policies promoting private sector solutions, for example, through tax incentives or increased use of contracting (Bishop & Waring, 2016).

The ambition of this paper is to primarily be descriptive in terms of pattern recognition and comparison across the two countries and two sectors. However, this descriptive analysis can be used as a stepping stone for formulating explanatory hypotheses, which might be based on differences in national political culture and institutional structure and differences in the specific tasks of the two sectors (Pollitt, 2005).

Design and methods

We have chosen to compare Denmark and Finland as examples of Nordic welfare states of similar size facing relatively similar economic shocks. We have further chosen to compare health care and higher education, as they represent two sectors that both countries have been committed to, with a high level of public sector involvement. Furthermore, both sectors have historically been characterised by a relatively high degree of autonomy based on the high knowledge content and dominance of academic and medical professionals.

Denmark and Finland are two Nordic countries that have both undergone relatively severe economic crises in the 1980s/early 1990s and post-2008. Both countries experienced negative economic growth rates after the 2008 crisis, and both have been slow to recover, as illustrated in figure 1.

Figure 1: Economic growth in Denmark and Finland compared to EU28

Source: Nordic Statistics 2015

The slow growth rates are also reflected in public expenditures on health and higher education. Both countries have experienced stagnating growth rates, particularly in education, but also in health from around 2009 to 2011. Adjusting for inflationary pressures, OECD health data even shows negative growth rates in real terms for health care in Finland for 2013-2014 and in Denmark for 2009−2011 and again in 2012−2013. These negative growth rates are quite unusual in the Nordic region.

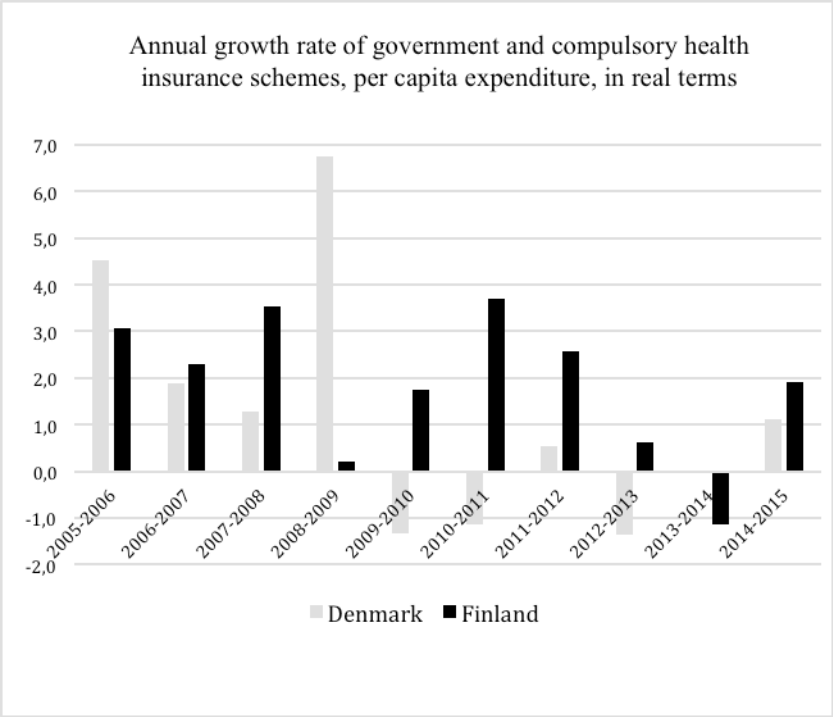
In the following section, we will analyse the patterns of policy responses within the two sectors in Denmark and Finland in light of the general economic downturn.

On the one hand, we can expect resilience in the welfare state policies in such countries (Pierson, 2000; Magnussen et al., 2009). On the other hand, the high level of public expenditures necessitates action in times of crisis. Analysing crisis reactions in the two countries can provide insights about how such competing pressures are balanced in the current Nordic welfare states.

The methods for data collection and comparison include reviews of previous academic publications on the topic of crisis reaction within health and higher education in the two Nordic countries and systematic tracking of policy initiatives as they appear in such publications. We also use primary data sources in terms of white papers and reform documents in the two countries from a recent investigation on "The global crisis and the public sector in Nordic Countries".[1]

Based on this material, we develop four case descriptions representing health and higher education in the two countries. We compare the cases and identify similarities and differences across sectors and countries using our conceptual framework of crisis reactions. The information is summarised in a table before we turn to a discussion of the results.

Figure 2: Annual growth rate of government and compulsory health insurance schemes, per capita expenditure, in real terms



Source: OECD Health Data 2016

Higher education in Denmark

The higher education landscape in Denmark consists of nine *academies of professional higher education* offering short and, to some extent, medium-cycle higher education, primarily within the technical and mercantile field; seven *university colleges* offering mainly medium-cycle higher education programmes, mostly directed towards the public sector; and *eight universities* offering education programmes according to a 3+2+3 Bachelor's, Master's and PhD structure and responsible for the bulk of public research activities. Mergers and post-merger reorganisations have been ongoing both before and after the crisis.

Funding for higher education and research had been growing until 2015. This was part of a deliberate attempt to boost the knowledge base and strengthen the long-term competitive position of Denmark in the global economy. Both liberal/conservative and socialist-led governments have supported this basic idea. For universities, on which we will focus, this is reflected in the fact that total income rose by 27% (in fixed terms) from 2007 to 2014 (Danske Universiteter, 2014, 2015).

Recently, this growth has been replaced by significant cuts in core university funding as well as in the funding allocated through research councils. This policy change was introduced after the election of a new liberal minority government in June 2015. In addition, a discussion about the current system of student grants is now on the political agenda. Denmark has a very favourable and expensive student grant system compared to most other countries. A reform of this seems likely in the future, converting a higher proportion of student grants into student loans.

Whereas cutbacks in other parts of the public sector were implemented in the years immediately following the financial crisis, the higher education sector was shielded for several years and has only recently been severely affected. This was due to a broad political consensus behind the idea of research and education as key competitive factors for Denmark.

Funding for higher education in Denmark has been results-based since the 1990s, as universities get resources for every student passing an exam. This system has been further developed with funding linked to throughput. A bibliometric indicator system (inspired by Norway) was introduced in 2010 for the allocation of a minor part of basic research funding (Schneider & Aagard, 2012). The principles guiding resource allocations in the different funding streams are politically determined, but the earned resources are given to the universities as lump sums, giving them considerable autonomy over the internal distribution of resources. The lump sum principle is in accordance with the principles of the 2003 university and management reform, in which universities were formally transformed into independent institutions by introducing boards with an external majority and chairs and by replacing elected leaders at all levels with appointed leaders, thus dismantling the traditional collegial leadership (Hansen, 2016).

In line with this autonomy and management policy, the government has used a cost-saving strategy in the implementation of recent university cutbacks. The universities have had different reactions to this. Some universities are using their savings as a temporary measure, but most universities are planning or have already implemented reductions in administrative and academic staff (cost-saving and reorganisation logics). Additional actions at the university level include the closure of a number of study programmes and adjustments in the workload of staff in the remaining study programmes, for example, by applying a higher teaching load and reducing administrative support (programme logic).

The oldest and largest of the universities, the University of Copenhagen, was the first university to adjust its organisation to the new reality. In phase 1 of the adjustment plan, more than 400 positions were terminated. The university expects a permanent reduction of 5% of total expenditure when the plan is fully implemented in 2018.

When the adjustment process was initiated, the management stated that they would use a strategy based on a programme logic, shielding core activities and focusing cutbacks on support functions. It has since been questioned whether the implementation has followed this strategy in practice, and the extent to which

core activities have been affected has been debated. It seems that management has also used a strategy based on a cost-saving logic.

Recently, phase 2 of the adjustment plan was launched. In this phase, the deans have been given the task of carrying out an organisational analysis and putting forward proposals for efficiency gains, increased earnings and additional cost savings in the coming years, with the aim of preparing for further reductions in 2019. In phase 2, among other things, different ways of organising shared services have to be evaluated, indicating that management plans to use strategies anchored in a reorganisation logic in addition to the strategies based on cost-saving and programme logics.

The broader picture is thus of a state that has been concerned with the introduction of new management practices based on general management and more extensive use of economic incentives. In recent years, this has been accompanied by cutbacks in funding for education and research. Performance measurements have been used for a number of years and include activity/throughput and more qualitative measures related to the ability to increase external funding and publications, as demonstrated through the bibliometric indicator system. To some extent, this represents an ongoing challenge to the autonomy and independent research orientation of academic professionals, although the actual impact varies across different institutions.

There are no private universities in Denmark, and user fees have not been considered as an option for funding general university education due to the heavy emphasis on equitable access. This is also reflected in the relatively generous student allowances given to all students in Denmark (almost 6000 DKK or €800 before taxes per month). The allowances have been maintained at this relatively high level, although the government has recently signalled ambitions to replace parts of the funding with student loans.

Since the 1980s, the number of continuing education programmes with user payments has significantly increased. Universities are also increasingly looking to international students and e-learning programmes as potential sources of additional income.

Health care in Denmark

As mentioned above (figure 2), Denmark experienced negative growth rates in public health expenditures in real terms for several years after the 2008 economic crisis. This remarkable development followed a long period of gradually tightening control of health expenditures in Denmark. The control regime has been facilitated by the institutional structure with annual budget agreements as coordinating instruments backed by national level control over tax-based financing. The annual budget negotiations between the government and decentralised authorities were introduced in the early 1980s in response to a severe economic downturn and serious challenges for the public finances in Denmark. This can be considered a gradual programme change that was accompanied by a push towards changing management practices from professional and local management

towards general and centralised management practices. The purpose of the budget agreements is to determine target expenditure and taxation levels. From the late 1990s, this was further reinforced by a "tax-stop" implemented by the liberal-conservative governments from 2001 to 2011. State control over health care financing was also strengthened by a major structural reform in 2007 (agreed to in 2004), in which the previous counties were replaced by five new regions with health care as their main responsibility. Importantly, the regions were not allowed to issue taxes, and financing of health care was thereby fully and formally centralised at the state level. The 2007 "structural reform" is an example of reorganisation logic in Danish health policy, allowing for new inter-organisational relationships and tighter steering. It also paved the way for different types of cost-saving logic, which have all been applied in the health sector (Olejaz et al., 2012). Decremental cost savings are applied in the form of 2% annual reductions in state funding based on the expectation of productivity increases. This has led the regions to apply reorganisation logic in rationalising their infrastructure and processes. Business case logic, in the form of health technology assessment and evaluation of regional level projects, has also been applied as part of this process. In some cases, this has led to substantial savings through closing down hospitals.

The process of strengthening economic control logic has been ongoing and has been further strengthened since the 2008 crisis. A significant step towards stronger state control came in 2013, with the introduction of a "budget law" under which the national parliament sets four-year budgets for regions and municipalities. These nationally set budgets are enforced by automatic sanctions for budget deficits.

Performance management focusing on productivity is an integrated part of the economic steering system between the state and regions and within regions (between regions, hospitals and GPs). The activity levels of hospitals and regions are measured through a DRG system, which was introduced as a tool for benchmarking and economic steering in the 1990s (Olejaz et al., 2012). While the bulk of the state financing of regions remains in the form of block grants, a minor (5−10%), yet important, portion comes through activity-based funding. The regions only receive this funding if their activity is above a certain target level. The regions are free to develop their own internal steering systems, and most have opted for a higher level of activity-based funding for their hospitals. This is implemented through hospital-level steering contracts/agreements. Both the national and regional levels have developed procedures for applying business case logic in their assessment of health technologies, projects and activities.

Clinical and process-related quality data are used by national and regional authorities for management and for comparisons within and across regions. The national authorities have the power to investigate quality breaches and may intervene in cases of poor performance (Vrangbæk & Byrkjeflot, 2016). Yet in most cases, this is handled at the regional level, where poor performance may result in dismissing the hospital management or reducing the autonomy of the hospitals. In a general context of reductions in hospital facilities, another option

for the regions is to close down departments or hospitals. The development of performance management schemes started before the current crisis, but their importance has been further increased by the economic situation. It represents a gradual and ongoing response, providing a knowledge infrastructure to pressure hospital owners and hospitals to deliver higher volume and better quality for the allocated funds. Some of these performance management schemes also represent challenges to professional autonomy and decision making, as they are based on the monitoring of adherence to standards and clinical guidelines (Vrangbæk et al., 2016).

On the financing side, a continued commitment has been made to maintaining a high level of public financing. User fees have not increased significantly. Private voluntary health insurance has increased, but not as part of an official policy to increase co-financing of public services (Alexandersen et al., 2016). Consecutive governments have encouraged the regions to increase their use of contracts with private delivery organisations. This has resulted in a gradual, but still limited, increase in private sector delivery. The other main driver of private sector involvement is an increase in direct purchasing by citizens. In addition to the gradual increase in private clinics and hospitals, more recently, private suppliers of home care services have increased, although the vast majority of these services are still delivered by public sector providers.

Higher education reforms in Finland

Finnish higher education consists of two separate systems: the university and polytechnic sectors. The two sectors have different identities, as the universities' research tasks are extensive and the Universities of Applied Sciences (UAS) have a clearer duty to respond to the needs of working life. The universities and UASs both offer teaching in first and second cycle degrees, and the third cycle of doctoral degrees is the specific domain of the universities (Aarrevaara et al., 2013). Finnish universities are autonomous units either governed according to public law or according to legislation relating to foundations. Only two universities are run by foundations, and the governance arrangements are different in the two models of universities.

In Finland, social and health-related reforms and higher education reforms have similarities, one of which is a key target of increased efficiency. Reforms should generate not only new structures and models for operation but also savings. The reform of the university sector in Finland has been going on since the early 1990s, when the polytechnic sector was founded. This meant a significant increase in the volume of higher education, and the system developed into a comprehensive but also financially burdensome network. More than 80% of the funding for universities is derived from taxpayers, either directly or through competitive funding. The most important sources of funding are the Parliament, the Academy of Finland, the Finnish Funding Agency for Innovation and the European Union.

Since 2015, the starting point for the funding formula has been quality, effectiveness and internationalisation. Universities' performance targets are agreed upon in negotiations between the Ministry of Education and Culture and the individual universities. From 2017 onwards, a new funding formula will have a greater emphasis on quality, relevance and effectiveness. Strategy-based funding will increase from 10% to 12%, with the aim of increasing the impact of universities. This will slightly increase the central control of the ministry, as the new funding formula allows more funding to be controlled by annual negotiations between the universities and the ministry.

The structural reforms have been the central platform for budget cuts, and due to the economic crisis, the universities have driven some initiatives for revised profiles to avoid a cheese-slicing strategy for budget cuts. The university sector has implemented structural reforms based on the Council of University Rectors' (UNIFI) reports. These UNIFI structural development reports are also the starting point for upcoming reforms in the next few years. In 2016, direct state funding for the entire university sector is approximately EUR 1.8 billion, 4% lower than in 2015. This pressure for budget cuts has been preceded by cutting the general price index subsidy, which has further hampered universities' financial planning. The universities will change the university sector activity profoundly, as they are obliged to combine the for-profit "project world" and the traditional non-profit "creative ethos".

Higher education reforms have profoundly affected the division of labour in academic departments, assessments of activities and professional autonomy. Reforms have meant a diversification of research and teaching work. Reduced administrative support in universities has meant a change in academic work, as more tasks that require administrative expertise have shifted to the shoulders of the academic staff. For example, the University of Helsinki is the country's largest university, representing about 25% of the university sector. Its economic adjustments over the next four years will amount to more than 80 M EUR, which is why it has announced plans to cut about 1,000 redundant postions by 2020. The largest universities have had disproportionate success in gaining funding from the Academy of Finland and the Finnish Funding Agency for Innovation. The budget cuts for these two main funding agencies will therefore have a big effect on the largest universities and force them to further cut their budgets in the coming years. According to the Universities Act, the universities have to collect fees from students who are non-EU or EEA citizens participating in university foreign language Bachelor's or Master's degree programmes (Cai & Kivisto, 2013). The universities can decide the level of fees according to their governance model, and the minimum charge is 1500 € /year. There is an obligatory scholarship scheme, and the fee does not apply to students who take part in exchange studies or doctoral degrees.

Summing up, it is clear that the higher education sector in Finland has been subject to relatively stark cost-savings logic. The savings logic in this situation is based on a combination of different strategies rather than a simple cheese-slicing approach. Several different managerial and strategic processes are applied, along

with the cost-saving and reorganisation logic. Significant decremental cuts are combined with more strategic cuts in research funding. At the same time, universities are being pushed to apply a stronger business case logic, even down to the individual employee level, and staff members have had to justify their performance when reapplying for their own jobs. Each university has been forced to apply strategic programme thinking when deciding how to adjust to the severe budget cuts.

Health care reforms in Finland

In Finland, the health care response to the financial crisis in the late 2000s was affected on the one hand by the experiences of the severe recession in the early 1990s and on the other by the decentralised governance structure of the health care and local government system. As a response to the recession in the 1990s, the government implemented several measures, such as the devaluation of the national currency and severe cuts in public spending, including constraints on a wide range of welfare programmes (Keskimäki, 2003). According to many assessments, the harsh policies resulted in a more severe and longer economic downturn compared to what would have happened with more moderate measures. In the first instance, the Finnish government considered the 2008 crisis temporary, hesitated to propose harsh cuts and chose to increase borrowing to cover increasing public spending.

In health care, the decentralised structure was created in the 1993 municipal governance and funding reform which dismantled the previous centralised steering and planning system and assigned the responsibility for organising health care and most public services to the municipalities, which had a median size of around 5,000 inhabitants. The central government still partly funds the health care system through block grants to the municipalities, but does not have direct steering power for the services except through legislation and high-level regulations.

Due to general economic constraints, the consequences of the decentralised governance structure did not materialise until the early 2000s, when the total health care spending started to increase, reaching a peak annual growth of more than 5% in 2000–2002. Another consequence was increasing regional discrepancies in the provision of services. In some areas, waiting lists for care had increased, resulting in 2004 legislation to control excessive waiting times (Jonsson et al., 2013).

Based on long-term projected trends in regionally disparate demographic and economic development in Finland, the government launched an initiative to restructure the municipal structure and public services in 2005. The programme was successful in launching a wave of municipal mergers. However, the outcomes of the programme have also been heavily criticised, as they created more complex steering mechanisms (Junnila & Pekurinen, 2016).

While the disagreement on how to reform the health and social care system has continued on a political level, several municipalities have started to imple-

ment local or regional initiatives to reorganise social and health service provision. This has contributed to a large variety of different organisational arrangements in social and primary health care in Finland. These include arrangements such as 1) integrated care organisations established by a group of municipalities and covering social and health and primary and specialist services; 2) arrangements separating the purchaser and provider functions within the municipal administration; 3) outsourcing services either partially (such as a health station or services outside working hours) or totally (all health and/or social services), and 4) public-private partnerships in providing services.

In public specialised care provided by hospital districts, which are federations of municipalities, the development has been somewhat different from health and social services in basic municipalities. When the financial crisis began in 2007, the growth rate of expenditures on municipal specialist services levelled off, but not to the same extent as in primary care. In 2007–2013, specialist health care spending increased by 20% in constant prices compared to a 1% increase in primary care, which clearly illustrates the difficulties the municipalities have in governing the hospital districts in the current Finnish health care system. However, the hospitals have also rationalised their activities, for instance, by increasing day surgery and decreasing the effective length of hospital stays. In specialist care, the development in organisational restructuring has also been differentiated. Some of the most common developments include 1) establishing public enterprises for diagnostic and support services, such as laboratory and laundry services; 2) introducing focus hospitals specialising in a limited specialist care area, such as orthopaedic surgery; and 3) introducing business-style management structures inspired by new public management.

It is worth noting that most of the developments described above have taken place without central government intervention. So far, successive governments have been unable to introduce comprehensive social and health care reform. The main conflict between the parties used to be the position of the municipalities in the reform. A kind of a breakthrough took place in 2014 when, after a failed attempt at reform, the right-wing and social democrat-led government collaborated with the opposition parties and agreed on an all-party proposal to reform the social and health care system. The proposed reform was based on the idea that the responsibility for organising and financing all social and health services would be given to five social welfare and health care regions. In the end the reform failed, mainly due to a provision in the constitution related to municipal autonomy (Saltman & Teperi, 2016). After the earlier proposal, it was probably easier for the current government to base a new social and health care reform proposal on disconnecting the municipalities and the organisation and the provision of social and health services and establishing a new self-governing administrative tier at the county level in Finland.

While a new reform is currently being negotiated (fall 2016), the government has given several outlines and draft bills of the planned reform. These outlines are complex, reflecting some disagreement between the parties in the government. A major objective of the reform is to strengthen central government

steering power. Due to this, the financing of services is proposed to come mainly from the state budget, at least at the start of the system, although the 18 self-governing counties would be organising the services. The financing reform also aims to simplify the complicated social and health care funding system. The government funding and integration of social and health services in organisation and provision is supposed to facilitate the achievement of the tight cost-containment target of decreasing the annual growth of health and social care expenditures to less than 1%. In addition to a major administrative and financing reform, the government intends to substantially increase provider choice for citizens, while also introducing a purchaser-provider split which will give private and third sector providers an equal position in providing primary care and a part in specialised care services.

In conclusion, the Finnish health care sector's response to the financial crisis has been multifaceted, reflecting the decentralised structure of the health care system. The response has been influenced by a series of attempts to reform the dysfunctional social and health care systems, which had begun before the financial difficulties. In the beginning, the government did not launch any marked cost-saving programmes, but the prolonged financial crisis has driven the cost-saving objectives in the ongoing proposals for social and health care reform. However, critics have suggested that the ambitious structural reform outlined by the government, with increasing choice and private provision, may not meet the tight long-term cost-containment target.

At the level of health and social care organisations, the responses have varied. While most organisations have probably applied crude cost-saving logic, some organisations have gone through extensive reorganisations of services based on approaches such as thorough administrative integration, public private partnerships and outsourcing. So far, evidence on the effectiveness of these measures in terms of efficiency gains and cutting costs has been mixed.

Summarising across the cases

In addition to the changes mentioned in the table, we found extensive and intensified use of public management strategies, such as business case analysis, economic incentives and performance management. Private sector involvement is increasing in health care in terms of private voluntary health insurance and contracts with private providers in both countries. Within the university sector, we observe strategies to increase private funding for research in response to cutbacks in public funding.

Table 3 summarises the observations across countries and sectors

	Denmark		Finland	
	Health	**Higher education**	**Health**	**Higher education**
Cost saving	Ongoing 2% cuts Negative growth rates in 2009−2011 and 2012−2013	Major cuts in 2016−2019 Reduction in research funding Staff reductions 2016->	Negative growth rates in 2008−2009 and 2012−2013	Major cuts in 2016−2019 Reduction in research funding Staff reductions 2016->
Reorganisation	Structural reform 2007: larger regions and municipalities Ongoing mergers of hospitals	Mergers and post-merger reorganisation both before and after the crisis. National Research Funding reorganised 2014	Structural reform 2016 to create regions for health care Ongoing mergers of hospitals	Ongoing since 1990s
Programme change	Marginal	Closing study programmes Research funding changed towards innovation/ entrepreneurship	Marginal	Closing study programmes Research funding changed towards innovation/ entrepreneurship

Discussion

Starting with the overall picture, we observe that a wide range of different strategies have been employed in the two countries and across the two sectors after 2007. A clear similarity is the application of the cost-saving approach to budget regulation. A likely explanation is that this strategy does not invoke strong opposition from specific groups, but rather spreads the burden across many actors. Avoiding blame and the mobilisation of particular interest groups thus appear to be key factors in understanding policy responses (Boin et al., 2005).

However, the cost-saving strategy seems to have been insufficient as the crisis persisted. We therefore also observe several other strategies over time, including significant cuts in specific types of research programmes and the reorganisation of both health care and higher education.

In terms of our theoretical framework, we can thus observe that cost-saving logic is combined with reorganising and programme logics, although the timing and specific configurations vary across countries and sectors. Health care reforms have placed both intra- and inter-organisational changes at the forefront in the period following the economic crisis. In the Danish case, this reorganisation has been ongoing, as a response to the long-term challenges of changing demographics and constrained resources. Yet, the crisis has served as an opportunity to reinforce the ongoing reform trends.

In the Finnish case, several health care reform attempts have failed. However, the crisis appears to have aligned a number of political actors to enable a comprehensive reform in 2016, with several readjustments that are comparable to the "structural reform" in Denmark in 2007. Interestingly, the Danish reform was introduced in the boom years before 2007, although with clear rhetoric about the necessity to adjust to future contingencies due to an ageing population. In Finland, the attempts to reform the health care system also began in the mid-2000s, but due to the strongly decentralised structure of local government and political disagreements, it has been harder to reach agreement and to implement the reform ideas. This underlines the fact that national political and institutional factors matter for how and when the various crises response strategies are applied, as explained below.

Within higher education, it has taken longer to translate the general economic crisis to austerity adjustments. This is partly due to a general consensus in both countries that education and research are important conditions for future competitiveness. However, the recent cuts and transformations in education and research funding signal a reorientation and adjustment of priorities. "Employability" is a new key word in education, while relevance and entrepreneurship are important in the reorientation of research. This can be seen in the diversion of research funding schemes away from general research and into research that is specifically aimed towards innovation and entrepreneurship.

The reorganisations and cutbacks in both education and research have triggered further programme changes in terms of closing down study programmes and adjusting the tasks and composition of university staff. So far, these changes have been most dramatic in Finland, but similar changes are underway in Denmark also.

While programme changes have been implemented in higher education, this has proven more difficult in health care, where the obligation to provide services and the presence of strong interest groups inhibit the elimination of entire programs. Instead, the responses in health care have aimed to reorganise service provision and to adapt to the delivery structure through mergers and closing or converting smaller hospitals. This illustrates that overt limitations in access are much more difficult than adjustments of the delivery structure in the Nordic region. Yet, at the same time, it can be argued that there is a tendency to lower service levels tacitly in health care as well as higher education. Within health

care, this has fuelled a demand for private sector alternatives, while this is not yet the case in higher education.

The three themes of "management", "measurement" and "markets" appear to be important underlying parameters for the policy management adjustments in both countries (Currie & Martin, 2016). Business case logic, performance management and the increased use of incentives have been applied in both countries. The "market" dimension has been more subsumed due to the need for control over finances. However, the rhetoric around the current reform in Finland and elements of increasing reliance on private financing and delivery in both countries point in the "market" direction.

Several types of critique can be raised against our theoretical framework. First, it is clear from the preceding discussion that it can be very difficult to disentangle the different types of strategies, as they may be combined, layered and nested within each other. Second, it is often hard to ascribe clear causality between the crisis and the application of the strategies. Many initiatives might have happened independently of the crisis or may have simply been part of a broader macro trend that became inscribed in the crisis narrative, as this can be convenient for pushing unpopular changes (Mahoney & Thelen, 2010). This is further complicated by the fact that both crises and policy responses are subject to political framing and narratives (Stone, 1997; Currie & Martin, 2016). Furthermore, in empirical terms, it may be very difficult to disentangle the differences between "talk", "decisions", "implementation" and "results" in times of crisis (Pollitt, 2001). In spite of these critiques, it appears that the framework represents a useful first step in developing a more multifaceted understanding of response trajectories and narratives following economic crises in key welfare state sectors.

Conclusion

The aim of the paper was to identify the patterns of adjustments to economic crisis within two core welfare sectors: health care and higher education. While previous research has focused on cost containment, this paper has aimed to provide a more comprehensive picture of the often combined strategies of cost containment, reorganisation and programme logics within the core welfare sectors of health and higher education in the Nordic region. Across the two countries and two sectors, we have observed many similarities but also some important differences in response patterns.

Both countries tried to shelter the two sectors initially. Subsequently, they have relied on the continued strengthening of economic control and general performance management instruments in the systems. However, as the crises have continued over time, the growth rates of public expenditures in health care have been reduced, and in recent years, funding for education and research have also been significantly cut. We can thus observe a pattern of stepwise adjustment, where the severity of responses is stepped up as the crisis persists. Initial reactions include minor cost-saving exercises and relatively minor organisational

and programme adjustments. As the crisis persists, this is followed by more strategic changes. In this phase, we see new dynamics, as the crisis is used to legitimatise the tightening of control and ideologically infused changes. Ideology and tensions between central policymakers and decentralised delivery organisations become more important, along with the tendency for the state to take on more power.

The different types of adjustment strategies are often combined, either sequentially or concurrently. Yet, the specific trajectories vary across the two countries and sectors. In general, it appears that the specific nature of health care tasks and their high political salience has sheltered the sector from severe programme changes. It is hard to reach a consensus on eliminating or reducing treatment services, once a medical technology is in place. Instead, we see a general cost-savings logic being applied, leading to less overt ways of rationing at the organisational level, and we see structural changes in terms of mergers and reorganisation of the decentralised political-administrative systems.

Higher education has seen more dramatic programme changes − both in terms of eliminating particular study programmes and in terms of diverting research funding from general research programmes to more applied programs. Furthermore, the sector is currently subject to significant cost-saving and reorganisation logics in both countries.

In theoretical terms, our observations about the similarities and differences in response trajectories underline the opportunity to further develop the framework into a more detailed empirically founded typology to analyse the combined response trajectories at both central and decentralised levels.

All in all, we can confirm the notion that the external shock of an economic crisis can serve as a window of opportunity for imposing new policy initiatives and reinforcing ongoing efforts to tighten control in welfare sectors. The logics of cost containment, reorganisation and programme changes have been applied in both countries, and there has been a tendency to move from minor, incremental changes to more significant interventions as the severity of the crisis has persisted.

In the theory section above, we briefly introduced the national political culture and institutional structures of the two countries and differences in the specific tasks of the two sectors as parameters that might shape crisis responses. In our case, we compare two countries with relatively similar political structures. Both have parliamentary systems with a tradition of minority and coalition governments, and both have a strong element of decentralisation in the management of the welfare state. This would lead to expectations of high resilience to change, and indeed we have seen a relatively long period in which the two sectors experienced fairly stable increases in funding and limited structural changes. However, based on the analysis of changes, we can conclude that this picture has changed in the period since 2008. A number of changes have been implemented in both sectors in Finland and Denmark. One explanation is that the policy capacity of the central state in both countries has been strengthened over time and that this has been facilitated by the crisis awareness fostered by the experience of

previous crises in the 1970s and 1980s. Furthermore, policy elites in the two countries remain relatively small, and the highly coordinated nature of the economies facilitate policy responses once a consensus about the need to react has been established.

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Notes

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